CHESTERFIELD COUNTY TELEPHONE REASSURANCE PROGRAM - SENIOR ADVOCATE'S OFFICE

Application for Services

Participant Information

Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Home Telephone Number: _____ Referred By: _____

Email: _____

Which hospital do you prefer to use? _____

Do you have a File of Life card? _____ Birth Date: _____

Interview Questions

Please answer the following questions:

1) Do you want to have a telephone assurance call 2-5 times a week?

2) What would you like your telephone caller to know about you?

3) What interests/activities are important for you to share with them?

Contacts

Case Manager or Social Worker:

Name: _____Relationship: _____

Organization: _____ Daytime Phone: _____

Primary Physician:

Name: _____ Group #: _____

Hospital: _____ Daytime Phone: _____

Emergency Contact or Neighbor:

Name: _____ Relationship: _____

Evening Phone: _____ Daytime Phone: _____

Chesterfield County Senior Advocates Office, P.O. Box 520, Chesterfield, VA 23832
Phone Number 804-768-7878

Continued from page one…

Emergency Contact:

Name: _____ Relationship: _____

Evening Phone: _____ Daytime Phone: _____

Do either of your emergency contacts have a key to your home? _____

If yes, who? _____

Demographic Information – For Statistical Purposes Only

(Check box that applies to participant)

MARTIAL STATUS

☐ Never Married ☐ Married ☐ Divorced/Separated
☐ Widowed

GENDER

☐ Female ☐ Male

LANGUAGES SPOKEN

☐ English ☐ Spanish ☐ French
☐ Russian ☐ Hebrew ☐ Other: _____

Today's Date: _____

Return completed form to: Debbie Leidheiser, Chesterfield County Senior Advocate, P.O. Box 520, Chesterfield, VA 23832